BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

Meeting Date: 08/18-19/04	Division: Community Services
Bulk Item: Yes X No	Department: Social Services Transportation
	Social Services Director: To Toone
	Louis LaTorre
AGENDA ITEM WORDING: Approval of a co	ntract between Monroe County and WebMD
on Medicaid status as well as Medicaid number:	llow Monroe County Transportation personnel to check s. As we do the billing for Medicaid eligible Medicaid oftware for the past 7 years to obtain this information and
PREVIOUS RELEVANT BOCC ACTION: N/A	\
CONTRACT/AGREEMENT CHANGES: N/A	
STAFF RECOMMENDATIONS: Approval	
TOTAL COST: \$49.90 (\$24.95 1st month and \$24. BUDGETED: Yes X No COST TO COUNTY: \$49.90 (\$24.95 1st month and \$24. SOURCE OF FUNDS: 102-61505	
REVENUE PRODUCING: Yes X No	
APPROVED BY: County Atty OMB/Pu	rchasing Risk Management
DIVISION DIRECTOR APPROVAL:	James Malloch
OCUMENTATION: Included X	To Follow Not Required
DISPOSITION:	AGENDA ITEM # CB

Revised 1/03

MONROE COUNTY BOARD OF COUNTY COMMISSIONERS

	CONTR	ACT SUMMARY	
Contract with:	WebMD	Contract #	
		Effective Date:	April 21, 2004
Contract Dyes	o/Dagaminėjami	Expiration Date:	No Expiration Date
Contract Purpos	e/Description:		
status as well as	will allow Monroe County Medicaid numbers. As we c rips. We have been using th	do the billing for Mo	onnel to check on Medicaid edicaid eligible Medicaid ast 7 years to obtain this
information and	in the past a contract/fee wa	as not required.	
			· · · · · · · · · · · · · · · · · · ·
Contract Manage	er: Jerry Eskew	4425	Transportation/1
	(Name)	(Ext.)	(Department/Stop #)
for BOCC meeti	ng on 08/18-19/04	Aganda Daadlina	09/02/04
for BOCC meen	ng on 06/16-19/04	Agenda Deadline:	08/03/04
	CONT	RACT COSTS	
Budgeted? Yes Grant: \$ County Match: \$	ADDIT	Ics: 102-61505-530	r Portion: \$ 74.85 0-520-
	CONTR	ACT REVIEW	
Division Director Risk Managemen O.M.B./Purchasir County Attorney Comments:	t Sid-Of Yes No	Rev Down Shuff	Date Out 100 8/3/04 3-2-04 2/3/04 3/3/04

WcbMD 3055 Lebenon Road Bldg.3 Suite 2000 Nashville, TN 37214

If you have questions on how to complete this form or on the status of your enrollment, please call the enrollment help desk at 1-800-845-6592.

Florida Medicaid Enrollment for Real-Time Transactions For WebMD Office

For WebMD Office
Please complete all information. Mail this form to the address listed above.
Provider/Group Name: MONTOE County Transportatio
Provider Address: 1100 Simonton St. Rm 1-181
Provider City, State, Zip: Key west F1 33040
Contact Name: Jern Es Kew
Provider Phone Number: 305-292-4422
Fax Number-for approval notice: 305-292-4411
Tax 10: 540302250553C FED ID 59-600749
Provider Number (must be nine digits): 0881511-00
 If Practice has multiple locations where eligibility will be verified, each location and corresponding provider number must be submitted for enrollment. Please copy form as needed. Provider number must be associated with the Practice/Physician name and location. Billing Agencies must have a specific provider number assigned by the AHCA (beginning with 99) along with submission of "intent and disclosure" and subsequent approval from AHCA for requesting eligibility data.
Please indicate all applicable HIP user names (please write clearly):
der Address: 1100 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

Revised 2/12/01

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ction VI – Ackno		ts						
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WebMD Office Subscriber Agreement (Provider Direct RT Only) 01/04

SUZANNE A. HUTTON
ASSISTANT CI JUSTY ATTORNEY

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Select One of the Following:				Comple	te Sections:	
New Users in New Provider Co	ustomer Organization			A, B, C,	O (next page) and WebMD (Office Subscriber Agreement
Adding New Users to Existing	 _	er Customer Organizations			(signed by primary contact)	
☐ Adding WebMD Office to Exist	ling WebMD Practice C	Customer Organizations and Us	ers		D (next page) and WebMD	
Also Select One of the Following:					- 	
□ Do NOT need access to	payers that require add	litional real-time carrier enrollm	ent.			
NEED access to payers to	that require additional r	eal-time carrier enrollment.				
		Carriers that may require addit	ional paperwork.			
Section A - Provider Customer Add	dresses and Contact I	nformation				
Organization Information		Billing Information (for Invoices	5)	M	iling Information (for Notificati	ions)
Organization Tax = 59 - 600017	49	Seme as Organization		5	Same as Organization 🔲 Same as 84	ing
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Kon west, do 30	307.0	City, State, Zip		Ci	y, State, Zip	·
3052924422 30	52924411	Phone	Fax	P1	one	Fax
Section B - Acknowledgements						
ACKNOWLEDGEMENTS						
have the authority on behalf of this Organ	nization and the providers	affiliated with this Organization (or	oliectively, the Or	yanization") to	Organization Name	
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Organization, I acknowledge that access t	lo and use of each catego	ry of Services are subject to this O	roanization's entry	into a subscr	iber I	
agreement for such services and each per	rson's entry into a user ac	reement for such Services. In activ	or the authority	granted by th	is ———	noe!
Organization, I agree to establish appropr	iale levels of access and	passwords for such persons to ens	sure use of the Wei	DMD Office W	eb	<i>y</i> 1
Sile and all Services in compliance with a	policable state and tedera	I laws and the applicable subscribe	er agreement.	 ,	Authorized Agent Title (print or ty	ne) Dale
Section C - Primary Contact				_		
Preferred UseriD	21. 41.				<u> </u>	
(this will be Your email address)	Salute (6)	First Name		MI	ESKers	Name .
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51-15:	1-27-46	Sk. Administr			H	

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This user will serve at the primary contact for the customer organization. All changes, including adding or deteting users, services or payers must be approved by the primary contact. All correspondence between WebMD and the customer organization, including welcome letters that contain each user's WebMD Office useriD and temporary password, will be directed to the primary contact.

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SCHEDULE IV

REAL-TIME CARRIERS

Please select the Real-Time Carriers to which you would like to submit transactions:

Αd	ditional Enrotiment Form Required
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Adg	titional Enrollment Form Required with ORIGINAL Signature
	BLUE CROSS BLUE SHIELD OF FLORIDA BLUE CROSS BLUE SHIELD OF TEXAS (Must be accompanied by form "Sample Letter" on Physician Letterhead) BLUE CROSS BLUE SHIELD OF NEW MEXICO (Must be accompanied by form "Sample Letter" on Physician Letterhead) BLUE CROSS BLUE SHIELD OF ALABAMA

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